

DOCUMENT RESUME

ED 311 317

CG 021 930

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TITLE Age and Sex Differences in the Treated Incidence of
DSM-III Child and Adolescent Psychiatric
Disorders.
PUB DATE Apr 89
NOTE 23p.; Paper presented at the Biennial Meeting of the
Society for Research in Child Development (Kansas
City, MO, April 27-30, 1989).
PUB TYPE Reports - Research/Technical (143) --
Speeches/Conference Papers (150)
EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Adolescents; *Age Differences; *Children;
*Incidence; *Mental Disorders; Patients; *Sex
Differences
IDENTIFIERS *Diagnostic Statistical Manual of Mental Disorders

ABSTRACT

In recent years notable advances have been made in the classification of child and adolescent psychopathology. The Diagnostic and Statistical Manual of Mental Disorders - III (DSM-III) has introduced a number of new diagnostic categories for child and adolescent disorders, yet little is known about how these new diagnostic categories are actually being used in treatment settings, or how the characteristics of the treatment populations compare to those of epidemiological samples drawn from the general population. In this study age and sex differences in the use of DSM-III child and adolescent diagnostic categories were examined within two types of treatment settings, inpatient and outpatient. Subjects were inpatients (N=899) and outpatients (N=687) ranging in age from 5 to 18 years. The results were similar to DSM-II in that a wide variety of DSM-III categories were represented in the sample and age and sex differences were identified in the distribution of these disorders. However, a more detailed analysis of the trends revealed that sex differences generally did not vary across age groups or treatment populations, whereas age trends differed for inpatient and outpatient populations. Thus, important similarities and differences between the two samples were revealed only when the interactions of age, sex, and treatment population were analyzed using categorical data modeling procedures. (ABL)

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ED311317

SECRET 077

DSM-III Classification 1

Abbreviated title: Age and Sex Differences in DSM-III

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Presented at the Biennial Meeting of the Society for Research in
Child Development, Kansas City, Missouri, 1989.

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Age and Sex Differences in the Treated Incidence of
DSM-III Child and Adolescent Psychiatric Disorders

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The authors wish to thank Jean Wenzel for her assistance with record collection and John Simonson for his computer and statistical expertise. We are also grateful to Dr. Emory Cowen for his helpful comments on earlier versions of this manuscript.

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Abstract

Age and sex differences in the use of DSM-III child and adolescent diagnostic categories were compared and contrasted with those found by DSM-II and epidemiological investigations. In this sample, sex differences within DSM-III diagnostic categories did not vary across treatment populations, whereas age trends did differ for inpatients and outpatients.

Age and Sex Differences in the Treated Incidence of
DSM-III Child and Adolescent Psychiatric Disorders

In recent years, notable advances have been made in the classification of child and adolescent psychopathology (Cantwell and Baker, 1988). DSM-III (American Psychiatric Association, 1980) introduced a number of new diagnostic categories for child and adolescent disorders, yet little is known about how these new diagnostic categories are actually being used in treatment settings, or how the characteristics of treatment populations compare to those of epidemiological samples drawn from the general population (Rutter, 1988). The majority of children who are in need of mental health services never receive them (Barchas, Elliott, Berger, Barchas, and Solomon, 1985; Saxe, Cross, and Silverman, 1988), and few mental health agencies report treated incidence data for those who are seen. Thus, knowledge concerning the distribution of basic demographic variables for DSM-III child and adolescent disorders remains fragmented, even though the integration of such knowledge is a prerequisite for advancing both research and treatment efforts.

Epidemiology

Epidemiological studies of child and adolescent psychopathology have become a major focus of psychiatric research (Rutter, 1988). Two extensive reviews of this literature (Gould, Wunsch-Hitzig, and Dohrenwend, 1980; Links, 1983) summarize

existing conclusions from epidemiological data. One major finding is that among disturbed children and adolescents, males outnumber females by two to one. There are other sex differences by specific disorders. For example, whereas males far outnumber females in the behavior disorders category, the sex ratio is approximately equal for emotional disorders (Eme, 1979).

In contrast to the substantial empirical evidence on sex differences in child and adolescent psychopathology, much less is known about other important variables, such as how the incidence of these disorders changes with age. One reason why epidemiological data have not shed more light on age differences is that many of these studies, rather than using an existing nosology, have employed idiosyncratic criteria of what constitutes psychopathology. This practice has prevented meaningful cross-study comparisons of epidemiological data (Gould et al., 1980; Links, 1983).

Treatment Populations

In comparison to epidemiological data, even less is known about the demographic characteristics of child and adolescent treatment populations. Cerreto and Tuma (1977) examined relationships between the demographic makeup of a treatment sample and the distribution of DSM-II diagnostic categories for child and adolescent disorders. They found that age and sex were the only variables significantly related to diagnostic category. There were significantly more males than females in their total

sample, and males were disproportionately represented in the behavior disorders category. Whereas psychoses and neuroses were diagnosed only at the upper age levels (14 and over), behavior disorders were diagnosed more frequently in children 13 and younger. Cerreto and Tuma (1977) concluded that the DSM-II diagnostic categories for children and adolescents were being employed, and that the Transient Situational Disorders diagnosis was being overused in the adolescent age range. This study is the only report of age and sex differences across DSM-II child and adolescent diagnostic categories, and serves as a model for the present investigation of DSM-III disorders.

Treatment Setting

One obvious but important factor that relates to diagnostic judgments in child and adolescent psychopathology is the setting in which the disorders are treated (Klar, 1987). Pfeffer, Plutchik, and Mizruchi (1986) compared the prevalence of various DSM-III disorders in a sample of psychiatric inpatients, outpatients, and nonpatients. They found that inpatients were much more likely than outpatients or nonpatients to exhibit poor impulse control and reality testing, resulting in more severe and chronic psychiatric diagnoses. In contrast, outpatients were much more likely to be diagnosed as exhibiting Adjustment Disorders than either inpatients or nonpatients. The generalizability of these findings is limited to the age range of their sample (all preadolescents, ages 6-12), and by the fact

that age and sex differences were not examined across diagnostic categories.

Overall, the use of DSM-III child and adolescent diagnostic categories is likely to differ by treatment setting, with more severe and chronic disorders requiring inpatient treatment. Also, important subject variables (such as sex and age) may differ in inpatient and outpatient populations. Thus, a truly comprehensive study of the use of DSM-III diagnostic categories must include a wide age range from both treatment populations.

Research Questions

In the present study, age and sex differences in the use of DSM-III child and adolescent diagnostic categories were examined within two types of treatment settings (Inpatient/outpatient). The main purpose of this investigation was to determine if and when age and sex differences occur among these diagnostic categories, and whether or not these differences vary across inpatient and outpatient treatment populations. A second purpose of this study was to compare these results to those of DSM-II (Cerreto and Tuma, 1977) and previous epidemiological investigations employing DSM-III diagnostic criteria.

METHOD

Subjects

Subjects were 899 inpatients and 687 outpatients ranging in age from 5 to 18 years ($\bar{x}$ = 13.38; SD = 3.76). Fifty-two percent

of the sample were male, 48% were female. All were seen for diagnostic evaluation by trainees and staff through either a child and adolescent psychiatry outpatient clinic or as inpatients at a large upper state New York teaching hospital from January 1979 through September 1986. A combination of clinic files and computerized billing records were searched in an effort to include in the sample all children and adolescents who received a psychiatric diagnosis. Inpatients from Psychiatric, Pediatric, and Emergency Room admissions with a DSM-III diagnosis were included so that the various types of disorders typically seen in these areas would be represented in the overall sample. The hospital serves both urban and suburban populations, covering a wide range of socioeconomic and ethnic backgrounds, and provides a range of psychiatric diagnostic and treatment services to children, adolescents, and their families.

Procedure

For all subjects, patient case number, age, sex, and DSM-III diagnosis were recorded. Subjects were separated by sex and type (inpatient/outpatient) and placed in one of three age categories: Childhood (ages 5-9), Preadolescence (ages 10-13), and Adolescence (ages 14-18). These age groupings were used for the statistical analyses because they demarcate important transitions in cognitive, psychosexual, social, biological, and educational development (Rutter and Garnezy, 1983).

Subject's primary Axis-I diagnosis determined their DSM-III diagnostic category. Diagnostic subcategories (e.g. Attention Deficit Disorder with hyperactivity, without hyperactivity, and residual type) were collapsed so that only major diagnostic categories (i.e. Attention Deficit Disorder) were used for classification purposes. In all, nine diagnostic categories were derived from the DSM-III nosology (see table 1). An "Other

 Insert Table 1 about here

Disorders" category was created by combining five diagnostic categories (see Table 1) whose treated incidence was very low (less than 2% of the overall sample). This was done to minimize the number of empty cells (zero frequencies) in the statistical analyses.

RESULTS

Because the three independent variables (sex, type, age) and the dependent variable (diagnostic category) were nominal, categorical data modeling procedures (SAS, 1985) were used. Specifically, the Grizzle, Starmer and Koch (GSK) weighted least squares approach (Grizzle, Starmer, and Koch, 1969) was employed. The GSK method fits linear models to the functions of nominal data, thus allowing categorical variables to be analyzed within a general linear model framework.

Table 2 summarizes frequencies and percentages of diagnoses for males and females within the three age groupings. Although

Insert Table 2 about here

the sex ratio for the total sample was approximately equal, the categorical data model analysis indicated a significant association between sex and diagnostic category ($\chi^2 = 38.93$, $df = 8$, $p < .0001$), demonstrating that the distribution of males and females across diagnostic categories was disproportionate to the overall sex distribution. The sex x type, sex x age, and sex x type x age interactions all failed to reach significance ($p > .05$).

The frequency and percentage of diagnoses for the three age groups are presented for inpatients and outpatients in Table 3.

Insert Table 3 about here

Of the total sample, 20% were between ages 5-9, 22% between ages 10-13, and 58% between ages 14-18. The categorical data model analysis revealed a significant association between type (inpatient/outpatient) and diagnostic category ($\chi^2 = 126.93$, $df = 8$, $p < .0001$) and between age and diagnostic category ($\chi^2 = 89.48$, $df = 16$, $p < .0001$), as well as a significant age x type interaction

($X^2 = 33.92$, $df = 16$, $p < .005$). All of the remaining interactions failed to reach significance ($p > .05$).

Discussion

The primary purpose of this investigation was to examine age and sex differences in the use of DSM-III child and adolescent diagnostic categories with inpatient and outpatient populations. The present results were generally similar to those found for DSM-II (Cerreto and Tuma, 1977), in that a wide variety of DSM-III diagnostic categories were represented in this sample, and that age and sex differences were identified in the distribution of these disorders. However, a more detailed analysis of these trends revealed that sex differences generally did not vary across age groups or treatment populations, whereas age trends differed for inpatient and outpatient populations. Thus, important similarities and differences between the two samples were revealed only when the interactions of sex, age, and treatment population were analyzed using categorical data modeling procedures.

Sex Differences

The present study's sample differed from Cerreto and Tuma's (1977) in that the overall sex ratio was approximately equal. Although Cerreto and Tuma's sample size ($N=330$) was much smaller than the present study's, the sex ratio of their sample (65% male, 35% female) was consistent with past epidemiological data

(Gould et al., 1980; Links, 1983). However, recent epidemiological studies reviewed by Costello and Benjamin (In Press) found that while males outnumber females in the behavior disorder categories, females had a higher prevalence of emotional disorders. Thus, when both types of disorders were represented, as is the case with the present sample, the overall sex ratio in each of three epidemiological samples was found to be equal (Costello and Benjamin, In Press).

Within specific DSM-III diagnostic categories, some sex differences remained stable across the three age groups, while others fluctuated from one age group to the next. One example of the latter is the Conduct Disorder category, in which males outnumbered females by a two to one margin in the childhood and preadolescent age groups. This is consistent with Cerreto and Tuma's data (1977), which also found an unequal sex ratio in this category for children 13 and under. In the adolescent age group, however, this sex difference was not present in the sample. This diagnosis was used with more females during adolescence, thus evening out the sex ratio. The sex difference in the "Other Disorders" category also was primarily the result of a higher incidence of males than females in the Oppositional Disorder category (48 and 26, respectively) for the child and preadolescent age groups. Overall, males were over-represented in the "behavior disorder" diagnostic categories until

adolescence, at which time these diagnoses were equally utilized with both sexes in this sample.

Unlike the Conduct Disorder sex difference, males were consistently over-represented within all three age groups in the Attention Deficit Disorder category. In the adolescent age group, males outnumbered females by a two to one margin in the Schizophrenia/Paranoid category, whereas females outnumbered males thirteen to one in the Eating Disorders category. Sex differences of this magnitude suggest that powerful physiogenic, as well as psychogenic, factors play significant roles in these disorders (Eme, 1979). No sex difference was evident in the Affective Disorders category for any age group, suggesting that the preponderance of depression among adult females may not be reflected in the use of these diagnostic categories with child and adolescent populations. Future research on the continuity/discontinuity of Affective Disorders is needed to clarify this issue (Cicchetti and Schneider-Rosen, 1986).

Age and Population Differences

Age differences within DSM-III diagnostic categories were complex because they differed for inpatients and outpatients. There was an approximately equal number of outpatients in each age group, whereas the number of inpatients underwent a six-fold increase from preadolescence to adolescence. This was due to a six-fold increase in use of the more severe diagnostic categories (e.g. Schizophrenia, Affective Disorders, Eating Disorders).

Other categories, such as Conduct, Anxiety, and Adjustment Disorders demonstrated an increase in usage with age, and were more likely to be treated on an inpatient basis during adolescence. Thus, the same disorders treated during childhood and preadolescence on an outpatient basis may require more intense inpatient care during adolescence (Pfeffer, et al., 1986). Attention Deficit Disorder was primarily managed on an outpatient basis, and the use of this diagnostic category declined with age in both treatment populations.

As noted earlier, there were significant increases in the number of males diagnosed with Schizophrenia/Paranoid disorders and females with Eating Disorders in adolescence. The number of Affective and Adjustment Disorders diagnosed also increased sharply for this same age group. The increase in the use of the Adjustment Disorder category with adolescent inpatients may reflect an inappropriate over-reliance on this diagnostic category, as was found to be the case for DSM-II (Cerreto and Tuma, 1977). This appears to be especially true for female adolescent inpatients, who constitute 60% of this increase. It is not clear at this point whether or not this diagnostic category is being used properly, and what the consequences of its misuse might be (Andreasen and Hoenk, 1982). It is plausible that the usage rates of more severe diagnoses was distorted by the overuse of the Adjustment Disorder category in this sample. Future classification research will need to address this issue.

Overall, in this sample there was a general increase in the use of DSM-III child and adolescent diagnostic categories with age, which is consistent with the recent epidemiological findings noted earlier (Costello and Benjamin, In Press). The majority of the present sample (58%) fell in the adolescent age range (14-18); the dramatic increase in the treated incidence of severe DSM-III disorders in adolescence suggests that disturbances in the major biological, cognitive and socio-emotional changes during the pubertal period set the stage for later psychopathology (Rutter and Garmezy, 1983). The cross-sectional nature of the present study does not allow for the exploration of important research issues such as the continuity/discontinuity of disorders with development. Longitudinal studies performed within the framework of developmental psychopathology (Cicchetti, 1984) are needed to trace the course of developmental disturbances and how they come to manifest themselves in various forms of psychopathology.

Limitations and Future Directions

Two major factors limit the generalizability of the present research findings. First, although the overall sample size was large, all of the subjects came from a single treatment facility. As such, the present results, like those of Cerreto and Tuma for DSM-II (1977), represent the patterns of usage for DSM-III child and adolescent diagnostic categories for one treatment setting, and must be interpreted within this context. A second

limitation pertains to the inherent difficulties of archival data. In this study, diagnoses were made by many different staff members over an eight year period, and reliability data against a standard rater was not available. Thus, the classification data in this sample represents the actual clinical use of DSM-III diagnostic criteria with these treatment populations, rather than a more strictly controlled epidemiological one. The present study was an initial attempt at comparing the clinical usage rates of DSM-III child and adolescent diagnostic categories with those of epidemiological studies, and the results are best thought of as being "suggestive" rather than "conclusive".

The present study highlights the need to examine further the use of DSM-III child and adolescent diagnostic categories in inpatient and outpatient treatment settings. The reporting of such data by mental health agencies is an important step toward developing a comprehensive epidemiological study of these disorders (Earls, 1982). Clinical and research applications of DSM-III diagnostic criteria must inform each other, so that both of these efforts combine to expand our understanding of child and adolescent psychopathology. Such collaborative efforts will have a tremendous impact on the classification, treatment, and eventual prevention of these disorders.

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Table 1

Summary diagnostic categories derived from the DSM-III nosology.

1. Mental Retardation.
2. Attention Deficit Disorder
3. Conduct Disorder
4. Anxiety Disorders (Child and adult categories)
5. Other Disorders:
 - a) Other Disorders of Infancy, Childhood, or Adolescence
 - b) Stereotyped Movement Disorders
 - c) Other Disorders with Physical Manifestations
 - d) Pervasive Developmental Disorders
 - e) Substance Use Disorders
6. Eating Disorders
7. Schizophrenic, Paranoid, and Psychotic Disorders
8. Affective Disorders
9. Adjustment Disorders

Table 2

Frequency and percentage of diagnoses for males and females by age group.

<u>Diagnostic Category</u>	<u>Males</u>					
	5-9		10-13		14-18	
	<u>Freq</u>	<u>%</u>	<u>Freq</u>	<u>%</u>	<u>Freq</u>	<u>%</u>
Mental Retardation	14	1.7	13	1.6	22	2.7
Attention Deficit Dis.	50	6.0	21	2.5	9	1.1
Conduct Disorder	28	3.4	38	4.6	62	7.5
Anxiety Disorders	11	1.3	14	1.7	13	1.6
Other Disorders	31	3.7	26	3.1	19	2.3
Eating Disorders	1	0.1	1	0.1	7	0.8
Schizophrenic/Paranoid	0	0.0	4	0.5	111	13.4
Affective Disorders	2	0.2	17	2.1	89	10.7
Adjustment Disorders	67	8.1	61	7.4	98	11.8
	204	24.5	195	23.6	430	51.9

<u>Diagnostic Category</u>	<u>Females</u>					
	5-9		10-13		14-18	
	<u>Freq</u>	<u>%</u>	<u>Freq</u>	<u>%</u>	<u>Freq</u>	<u>%</u>
Mental Retardation	15	2.0	16	2.1	14	1.9
Attention Deficit Dis.	6	0.8	2	0.3	1	0.1
Conduct Disorder	13	1.7	13	1.7	55	7.3
Anxiety Disorders	7	1.0	14	1.9	8	1.1
Other Disorders	16	2.1	12	1.6	24	3.2
Eating Disorders	1	0.1	25	3.3	92	12.2
Schizophrenic/Paranoid	1	0.1	3	0.4	60	7.9
Affective Disorders	3	0.4	10	1.3	82	10.8
Adjustment Disorders	43	5.7	61	8.1	160	21.1
	105	13.9	156	20.7	496	65.6

Table 3

Frequency and percentage of diagnoses for inpatients and outpatients by age group.

<u>Diagnostic Category</u>	<u>Inpatients</u>					
	5-9		10-13		14-18	
	<u>Freq</u>	<u>%</u>	<u>Freq</u>	<u>%</u>	<u>Freq</u>	<u>%</u>
Mental Retardation	27	3.0	28	3.1	35	3.8
Attention Deficit Dis.	19	2.1	6	0.6	8	0.8
Conduct Disorder	14	1.5	16	1.7	69	7.6
Anxiety Disorders	1	0.1	8	0.8	15	1.6
Other Disorders	2	0.2	5	0.5	17	1.8
Eating Disorders	2	0.2	23	2.5	95	10.5
Schizophrenic/Paranoid	0	0.0	6	0.6	163	18.1
Affective Disorders	0	0.0	13	1.4	149	16.5
Adjustment Disorders	6	0.6	13	1.4	159	17.6
	<u>71</u>	<u>7.7</u>	<u>118</u>	<u>12.6</u>	<u>710</u>	<u>78.3</u>

<u>Diagnostic Category</u>	<u>Outpatients</u>					
	5-9		10-13		14-18	
	<u>Freq</u>	<u>%</u>	<u>Freq</u>	<u>%</u>	<u>Freq</u>	<u>%</u>
Mental Retardation	2	0.3	1	0.4	1	0.1
Attention Deficit Dis.	41	5.3	17	2.5	2	0.3
Conduct Disorder	27	3.9	35	5.1	48	7.0
Anxiety Disorders	17	2.5	20	3.0	6	0.9
Other Disorders	45	6.6	33	4.8	26	3.8
Eating Disorders	0	0.0	3	0.4	4	0.6
Schizophrenic/Paranoid	1	0.1	1	0.1	8	1.2
Affective Disorders	5	0.7	14	2.0	22	3.2
Adjustment Disorders	104	15.1	109	15.9	99	14.4
	<u>242</u>	<u>34.4</u>	<u>233</u>	<u>34.2</u>	<u>216</u>	<u>31.5</u>